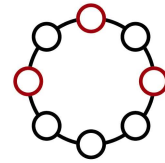


# Fatal Facts



**NCIS**

A publication of the  
National Coroners Information System (NCIS).

---

This edition of Fatal Facts features 31 coronial cases where recommendations have been made, with 6 of those cases highlighted in detail.

The cases covered in this edition deal with wide ranging issues from a number of states/territories.

Recommendations about motor vehicle accidents deal with the involvement of road conditions, weather, child booster seats, LPG conversions and barriers, whilst various issues surrounding deaths involving agricultural/industrial equipment are also considered.

Drowning is highlighted with recommendations in respect to the use of personal flotation devices, drowning in ponds and the importance of parental supervision. A number of recommendations in this edition also touch upon the treatment of persons in care (in both a prison, and police cell) whilst inebriated or drug affected.

As with previous edition, you will notice in some case studies we have referred to other cases on the NCIS which address similar issues.

We are receiving more and more requests for searches to be done on the NCIS, with a list of some of the searches conducted for coroners and other users provided in this edition. Finally, NCIS search tips are also included, to help enhance your use of the system.

Should you not currently have access to the NCIS, or wish to enquire about an information search, please contact the NCIS team on [ncis@vifm.org](mailto:ncis@vifm.org)

Jessica Pearse  
Manager, NCIS

**June 2005**

**Edition 7**

---

## Inside this issue:

Foreword	1
General Details	2
NCIS at a glance	2
Case Studies	3
Recommendations	9
Recent Research	15
Search Tips	16
Feedback Form	17

NCIS  
C/- Victorian Institute of  
Forensic Medicine  
57-83 Kavanagh Street  
SOUTHBANK VIC 3006

[ncis@vifm.org](mailto:ncis@vifm.org)

[www.ncis.org.au](http://www.ncis.org.au)

---

## General Details

In this edition of *Fatal Facts* we have looked at recommendations made within coronial findings for cases closed on the NCIS between 1 August 2003 and 31 October 2003.

If you seek further information regarding any of the cases contained in the proceeding pages, it is recommended that you visit the NCIS website at [www.ncis.org.au](http://www.ncis.org.au) log on using your authorised user name and password and find the particular case by clicking on the “NCIS Search” tab and selecting “Find Case”. The process in which to do this was demonstrated in the Search Tips section of the previous edition (Edition 6).

If you have forgotten your user name and password, or require advice regarding access to the NCIS database, please do not hesitate to contact our Applications Officer, Marde Hoy, at [mardeh@vifm.org](mailto:mardeh@vifm.org) or on (03) 9684 4323.

## NCIS at a glance

- ▶ Number of deaths on the NCIS (as at 30 June 2005): 94,353.
- ▶ Number of findings contained on the NCIS for cases closed between 01/08/2003 and 31/10/2003: 2577.
- ▶ Number of recommendations made for cases closed between 01/08/2003 and 31/10/2003\*: 31.

\* For a list of case reference numbers for these recommendations, please refer to pages 9 - 14.

*Disclaimer: The precis of coronial findings detailed within this publication have been produced by NCIS staff, with the best efforts made to accurately summarise the circumstances, findings and recommendations made by the coroner in each case.*

*Despite this, it should be noted that the material produced in this publication is not an authorised summary or exact replication of coronial findings, and as such, the original finding in its entirety should always be accessed should any reference to the content of a coronial finding be made.*

## Case Study 1:

### Narcotics overdose in custody.

NCIS Case Number: NSW.2002.2554

Local Case Number: 0100798/02

Finding Delivered: 15 August 2003.

Coroner: Deputy State Coroner Dorelle Pinch.

#### Summary:

The deceased had a known history of intravenous drug use, and at the time of his death was an inmate of a Correctional Centre.

As a standard practice, a targeted search was undertaken of the wing in which the deceased was housed. At that time, no drugs were located in the deceased's cell. It is presumed that the deceased, upon realising that his cell was going to be searched, swallowed whatever prohibited drug he had located in his cell. At muster time later the same day the deceased was found lying in his cell, unresponsive.

After being placed in the recovery position and given several injections of Narcan to reverse the effects of opiates, the deceased became semi-conscious and violent, necessitating restraint and sedation.

He deteriorated again and was rushed to hospital in a critical condition. Two days later he passed away.

Death was found to have resulted from Hypoxic Brain Damage due to Opioid Toxicity following the self-administration of heroin.

Following a thorough examination of the deceased's cell after his death, a number of drug related books and handouts from the drug rehabilitation program the deceased was participating in were discovered.

Also located was written information indicating that the deceased had access to, and had been using drugs while in custody.



<http://www.siu.edu/backissues/010226/needle.jpg>

Please note that the above image is included for aesthetic purposes only and does not represent the actual incident reported.

#### Recommendations:

The following recommendations were directed to the Minister of Correctives Services:

(1) Communication Of Medical Information To Families: Protocols be developed to allow the Medical Superintendent of a hospital to which a prison inmate has been transferred to communicate directly with that inmate's family about the inmate's medical condition as soon as practicable after admission.

(2) Training of Correctional Officers: The training program for Correctional Officers be reviewed to ensure that Correctional Officers are aware of the danger of the rapid onset of cerebral hypoxia following a narcotics overdose and the need, therefore, to seek immediate medical assistance for inmates suspected of such an overdose.

(3) Use of Videotapes:

(i) All searches of inmates and their cells be recorded in their entirety on videotape and

(ii) Accurate records of the places, times and outcomes of these searches be kept.

#### *Examples of other drug-related deaths in custody:*

NSW.2000.4653

SA.2000.1964

VIC.2000.3575

NSW.2000.4661

VIC.2000.2024

VIC.2000.3623

NSW.2001.4910

VIC.2000.2835

VIC.2001.282

## Case Study 2:

### Dangerous Overtaking Practices.

NCIS Case Number: NT.2003.12

Local Case Number: A0005/2003

Coroner: Territory Coroner, Greg Cavanagh

#### Summary:

At approximately 7:45am the deceased was traveling north along the Stuart Highway towards Alice Springs when the driver of a south-bound vehicle has attempted to overtake a bus by cutting a corner (so as not to be stuck behind the bus).

As a result of this action, the vehicle crossed to the wrong side of the road in front of the approaching vehicle driven by the deceased. Efforts by both drivers to avoid a collision proved unsuccessful.

The deceased sustained extensive injuries and was treated at the scene before passing away in hospital.

In investigating the death, the Territory Coroner found evidence that the dangerous manoeuvre of overtaking other vehicles by cutting corners was not uncommon in the area.

#### Recommendation:

That the Department of Infrastructure, Planning and Environment investigate the intersection with a view to either further discouraging the practice or controlling it by physical impediment.

#### *Other overtaking / road maintenance cases:*

NT.2000.178

Focuses upon the Stuart Highway, and the extension of double white lines throughout the area in order to prevent deaths associated with overtaking.

SA.2001.600/601

Recommendations made concerning the maintenance of country roads and the Australian Standard.



<http://driving.information.in.th/images/>

Please note that the above image is included for aesthetic purposes only and does not represent the actual incident reported.

### Case Study 3:

#### Child Booster Seats.

NCIS Case Number: SA.2001.24

Local Case Number: 0019/2001

Finding Delivered: 18 September 2003.

Coroner: State Coroner Wayne Chivell.

#### Summary:

The deceased, aged 7 years, was a rear seat passenger in a vehicle being driven in a easterly direction by his mother. At this time the deceased was sitting on a child booster seat. Also onboard were the deceased's grandmother and sister.

During the course of the journey, a vehicle traveling west turned suddenly and without warning into the path of the family vehicle. Following the collision, the deceased was treated at the scene by ambulance staff, before being transferred to hospital.

There, the deceased suffered a number of cardiac arrests, before his condition deteriorated, resulting in death from hypoxic-ischaemic encephalopathy.

During the inquest, the contribution of the 'Safe-n-Sound' brand 'safe-n-see' child booster seat to the death was investigated.

#### Recommendations:

That the Minister for Transport, in consultation with organisations such as the Royal Automobile Association of South Australia Inc, Kidsafe Child Accident Prevention Foundation of Australia, consider ways in which the following aims can be achieved:

1. That the use of booster seats in motor vehicles when transporting children between the age of 4 and 8 years should be encouraged;
2. That such booster seats should be of a type which comply with the relevant Australian Standard;
3. That such booster seats should be properly installed, and that if there are any doubts surrounding the method of installation and use, that professional help from the Royal Automobile Association of South Australia Inc or similar organisation should be sought;
4. That the use of worn or damaged booster seats should be avoided;



[http://www.babyuniverse.co.nz/site/page=item/item=B1506/itemname=Safe\\_n\\_Sound\\_Nova\\_Booster\\_Seat](http://www.babyuniverse.co.nz/site/page=item/item=B1506/itemname=Safe_n_Sound_Nova_Booster_Seat)

*Please note that the above image is included for aesthetic purposes only and does not represent the actual incident reported.*

5. That the manufacturer of such booster seats should consider ways in which the instructions for installation and use of such seats are conveyed in language understandable by the average consumer;
6. That manufacturers of such booster seats should also consider ways in which installation instructions can be attached to the seat in such a way that they will not be separated from the seat for the expected life thereof;
7. That further consideration should be given to the question whether the use of such booster seats in motor vehicles in relation to children between the ages of 4 and 8 years should be made compulsory.

A list of further recommendations were also suggested by Dr Ronald Somers (Head of the Injury Surveillance and Control Unit, South Australian Department of Human Services), and supported by Professor Roger Byard, Forensic Pathologist. A copy of the finding containing the recommendations formulated by Dr Somers, which were aimed towards the community, manufacturers and government, can be accessed on the following website:

[http://www.courts.sa.gov.au/courts/coroner/findings/findings\\_2003/newton.finding.htm](http://www.courts.sa.gov.au/courts/coroner/findings/findings_2003/newton.finding.htm)

## Case Study 4:

### Contact with overhead power lines.

NCIS Case Number: TAS.2002.58

Local Case Number: L0073/2002

Finding Delivered:

Coroner: Timothy John Hill, Tasmania.

#### Summary:

The Deceased was in the process moving a large shed from its foundations onto a large truck trailer when the boom of the mobile crane that the deceased was operating came into contact with 22KV high voltage overhead wires.

At the time of contact deceased was standing on very dry ground next to the crane operating the controls at the side of the truck.

Witnesses heard a loud crack sound and then saw arcing between the deceased and the crane controls and also arcing at the nearside front and rear tyres.

The deceased suffered electrocution, and died at the scene.

In the course of investigating the death it was determined that the overhead power lines at the point of the impact were approximately 700mm lower than the prescribed height above a road surface. However, it appears that the deceased still failed to observe the directions for the operation of cranes in close proximity to overhead lines (which are provided under the Australian Standards). Death was therefore determined to have resulted from a tragic error of judgment on the part of the deceased.

#### Recommendations:

As the power lines were not at the prescribed height above the road surface, the Coroner determined that they may have posed a hazard to other legitimate traffic movements on the roadway. It was recommended that the appropriate authority conduct an inspection of its installations to ensure that the prescribed clearances are being complied to.

### *Interested in deaths related to contact with overhead power lines?*

NSW.2001.1436

Hydraulic boom of concrete pumping truck.

NSW.2003.127

Extended jib of concrete truck.

NSW.2003.855

Crane jib .

NSW.2003.4039

Metal tape held by the deceased in a cherry picker.

TAS.2001.283

Dynamic lifter of tray truck .

TAS.2002.389

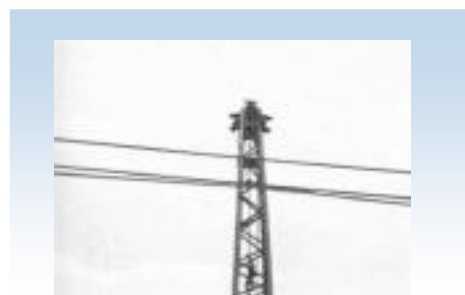
Agriculture metal piping transported on a four wheel motorcycle.

VIC.2000.3279

Felled sapling gum tree.

QLD.2001.1978

Metal irrigation pipes .



<http://www.craneoperator.com/images/Mishaps/Large-CranePowerLine-1.jpg>

*Please note that the above image is included for aesthetic purposes only and does not represent the actual incident reported.*

## Case Study 5:

### LPG Conversions.

NCIS Case Number: VIC.2002.2995

Local Case Number: 20022936

Finding Delivered: 10 October 2003.

Coroner: Phil Byrne, Victoria.



[http://www.cargas.de/images/oeko\\_3.jpg](http://www.cargas.de/images/oeko_3.jpg)

*Please note that the above image is included for aesthetic purposes only and does not represent the actual incident reported.*

### Summary:

The deceased (aged 8 years) and his 3 siblings were passengers in their fathers' vehicle (which was fitted with a dual fuel system, petrol/liquified petroleum gas). The vehicle had just been refueled with gas.

After departing the service station and continuing on their journey, there was a smell of gas inside the cabin of the vehicle. At that time the deceased's father ignited a cigarette causing an explosion to occur inside the vehicle.

The deceased was rescued from the burning vehicle by a passerby, and transferred to the hospital suffering 70% burns to his body. The deceased was treated at the hospital for his injuries for a period of 29 days before passing away.

The surviving children (aged 12 yrs, 10 yrs and 7 yrs) were all treated for extensive burns.

At the inquest, the Coroner stated that the case had thrown into sharp focus the fact that the regulatory regime concerning LPG gas conversions is deficient requiring urgent modification/ refinement. Further, the incident could just as easily have resulted in further loss of life.

### Recommendations:

#### (1) Issuing of roadworthy certificates for LPG converted vehicles:

Should only be conducted by a licenced motor vehicle tester who is also registered as an accredited installer with the Automotive Alternative Fuels Registration Board (AAFRB).

Or alternatively, that the vehicle is certified correct by an accredited AAFRB installer prior to being presented for a roadworthy certificate.

This principle should apply to all alternative fuel conversions.

#### (2) Vic Roads Information Notice:

In an attempt to capture non-compliant systems Vic Roads issue an information notice, for inclusion with annual registration notices, advising people of the need to ensure maintenance and checking of LPG conversions is carried out only by an accredited AAFRB workshop.

#### (3) Removal of Cylinders for testing:

Cylinders should be completely removed from a vehicle during the re-certification of the cylinder. The removal and re-installation work should only be undertaken by a licensed installer, to ensure safe reinstallation. Removal for testing has already been proposed in the new draft Australian Standard AS2337.2 *Gas Cylinder Test Stations - LP Gas fuel vessels for automotive use*.

This draft was released for public comment on 22/08/03, with the comment period closing on 31/10/03. (Draft 03423).

## Case Study 6:

### Roundabout Hazards.

NCIS Case Number: WA.2002.97

Local Case Number: 0088/2002

Finding Delivered: 31 October 2003.

Coroner: State Coroner Alastair Hope,  
Western Australia

#### Summary:

The deceased was riding a Honda 250CC motorcycle along a residential road when he lost control on the approach to a roundabout, colliding with the small limestone wall built on the structure.

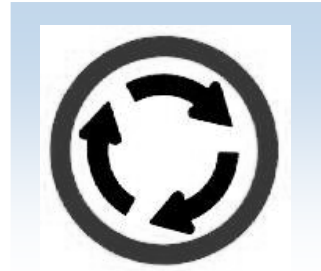
The deceased was transferred to hospital, where life was pronounced extinct.

Toxicological analysis later revealed that the deceased had a blood alcohol level of approximately 0.135%.

During the investigation into the fatality it was noted that the roundabout warning sign was missing and that the conspicuity of the roundabout was poor.

A joint inquest was held in relation to this fatality, along with the death of another motorcyclist involved in a single vehicle collision with a suburban roundabout (WA..2001.447).

A number of comments were made in regards to safety issues relating to roundabouts constructed by local Government authorities in Western Australia, along with concerns expressed by the Motorcycle Riders Associations of Western Australia.



<http://driving.information.in.th/images/>

*Please note that the above image is included for aesthetic purposes only and does not represent the actual incident reported.*

#### Recommendations:

1.that local government authorities not install limestone walls or other non-frangible hazards on roundabouts unless there is a very clear need to do so (this excludes the use of vertical elements such as trees when these are used in order to provide a roundabout with presence and visibility).

2.that road authorities pay particular attention to the use and availability of lighting in the area of roundabouts. In this context Australian-New Zealand Standard As/NZS 1158.1.3 : 1997 Road Lighting, Part 1.3 : Vehicular Traffic (Category V) Lighting - Guide to Design, Installation, Operation and Maintenance at page 37 notes that roundabouts will normally need lighting additional to the road lighting on the approach roads.

3.that the contributors to Austroads give consideration to altering the set out in their Guide documents so as to more clearly and simply identify hazards which should be avoided by local government.

4.suggestion that road safety reports which particularly address road environment issues in the context of fatal crashes should be prepared in respect of every fatal crash (not just those occurring within metropolitan areas).

5.in situations when the standard roundabout designs would not be appropriate, it was recommended that road safety audits be conducted prior to construction of roundabouts to identify safety issues.

6.important that to the extent possible, roundabout design includes stand-alone safety measures.

7.that lighting be treated as an important issue to be addressed in every case prior to the construction of any new roundabout.

# Recommendations

\* Case is featured in more detail in this edition

NCIS Case Number	Summary of incident
NSW.2002.2554*	<p>The deceased (an inmate of a Correctional Centre) had a known history of intravenous drug use who was found lying in his cell, unresponsive. After being placed in the recovery position and given medication to reverse the effects of opiates, the deceased became semi-conscious and violent, requiring restraint and sedation. His condition then deteriorated again, and he passed away in hospital two days later. At inquest, a number of recommendations to the Minister of Correctives Services were made.</p>
NSW.2002.5947	<p>The deceased left his business premises in 1988 to attend a work appointment. When he did not return to his residence, his disappearance was reported to Police. His body was later found, revealing a gunshot wound to the head. Following a Ministerial inquiry, the investigation into the death was reopened, with a recommendation made by the Deputy State Coroner to the Commissioner of Police that an approach be made again to the government to issue a further notice of reward and that on this occasion that reward should not have a sunset clause (thereby remaining an open reward until the case is solved).</p>
<p>NT.2001.80 NT.2001.81 NT.2001.82</p>	<p>A single vehicle rollover occurred after the driver became distracted by an intoxicated passenger, with the vehicle then becoming caught in ruts in the middle of the road. During the rollover, 3 passengers (ages 2 months, 30 years and 60 years) were ejected from the vehicle, all sustaining fatal injuries. Seat belts were not worn by the nine occupants of the vehicle, with the deceased infant held by her mother on her lap, and not in an approved child restraint. Investigation of the road surface found two wheel 'ruts' along the centre of the roadway, caused by either a heavy vehicle or from constant use by ordinary vehicles during the last wet period. These ruts ranged from 40 to 60 cm's in width, were 1.4 to 1.5 metres apart and 15cm's deep. The road surface, along with the distraction caused by the passenger, were deemed to be factors in the crash.</p> <p>It was recommended by the Territory Coroner that the appropriate authority responsible for the maintenance of the road from Mt Liebig to Kintore examine improving the road surface and regularly maintaining it to a safe standard.</p>
NT.2002.170	<p>After being apprehended by police for being intoxicated in a public place, and placed in a sobering up shelter, the Deceased was again placed into protective custody. During his time in custody at the Watch house the deceased complained of stomach pain, with an Ambulance called. The deceased was conveyed to hospital, and was later pronounced deceased.</p> <p>Cause of death: Acute Cardiac Dysrhythmia of an unknown cause.</p> <p>At inquest, a number of areas of concern were explored, such as the role of lignocaine and the administration of a "pink lady"; communication between Police and Night Patrol; the treatment of persons in protective custody; and in particular the treatment of persons who appear to be ill. Recommendations were made in regards to intoxicated individuals being taken directly to a sobering up shelter or the Watch house, rather than kept in the back of a paddy wagons.</p> <p>The Coroner called for adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons. It was also recommended that staffing at the Watch house be monitored and set at appropriate levels.</p>
NT.2003.12*	<p>A driver attempted to overtake a bus by cutting a corner. As a result, he has crossed to the wrong side of the road in front of the vehicle driven by the deceased, resulting in a collision. Following his investigation into the death, the Coroner recommended to the Department of Infrastructure, Planning and Environment to that they investigate the intersection.</p>
SA.2001.24*	<p>A vehicle turned suddenly into the path of the vehicle in which the deceased, aged 7 years, was a rear seat passenger.</p> <p>At inquest, the contribution of the 'Safe-n-Sound' brand 'safe-n-see' child booster seat was explored. A number of recommendations were subsequently made concerning the installation and use of booster seats by the community, manufacturers and government.</p>

SA.2001.616	<p>The deceased (aged 8 years), attended a combined twilight meeting of a harness racing club and fundraising event. Shortly after arrival, the deceased and her siblings began playing on the Maxi-Giraffe Supa-Bouncer inflatable bouncy castle, which was set up in the car park. During this time a whirlwind entered the car park, ripped the inflatable structure from its anchors and lifted into the air, causing a number of the children playing in the castle to fall to the ground. After a period of approximately 20 to 30 seconds in the air, the castle (with the deceased still holding on) crashed to the ground.</p> <p>The deceased was treated at the scene, and transferred to hospital. Her condition then deteriorated, with life pronounced extinct.</p> <p>The cause of death was deemed to be the result of a closed head injury.</p> <p>During the inquest, a number of issues relating to the bouncy castle were considered, with the recommendations made in relation to reviewing the relevant Australian Standard (AS3533), where it applies to inflatable structures.</p> <p>A copy of the finding is also assessable on the South Australian Coroner's Office website:  <a href="http://www.courts.sa.gov.au/courts/coroner/findings/findings_2003/">http://www.courts.sa.gov.au/courts/coroner/findings/findings_2003/</a></p>
TAS.2001.307 TAS.2001.309	<p>In dark and rainy conditions, the vehicle in which the deceased rear seat passengers were traveling failed to stop at the end of a dead end road, hitting a hydro pole and then traveling over the edge of the cliff. The vehicle fell to the rocks below, landing on its roof, and then becoming partially submerged in water. The driver and front seat passenger were able to climb out of the vehicle and raise the alarm, although the rear passengers were unable to be freed.</p> <p>Their bodies were found a few hours later within a few hundred metres of the car.</p> <p>It appears that neither of the deceased persons were wearing a seat belt.</p> <p>Issues arising at the inquest included the drivers manner of driving and the condition of his car; the condition of the road (and responsibility for its repair); the road signage in the area (and responsibility for its placement); and the adequacy of the barrier at the cliff face.</p> <p>A number of recommendations were by the Coroner pertaining to signage, the erection of barriers such as to provide an actual rather than nominal impediment to a car, and that the local Council and the Department of Infrastructure and Energy implement audit procedures allowing for the reporting and follow up of potential dangers by employees if they are seen in the normal course of their work.</p>
TAS.2002.58*	<p>The deceased was moving a large shed from its foundations onto a large truck trailer when the boom of the crane that the deceased was operating came into contact with high voltage overhead wires. The deceased suffered electrocution, and died at the scene.</p> <p>Recommendations were made concerning prescribed clearances of overhead power lines.</p>
TAS.2002.516	<p>The deceased (aged 17 months) was discovered face down in small backyard pond. With the assistance of the emergency operator, CPR was attempted by those in attendance before resuscitation was taken over by paramedics.</p> <p>The deceased was transported to hospital, and was later pronounced life extinct.</p> <p>During the investigation it was found that the pond was located approximately 2 metres from the steps at the back of the residence. It was approximately 2.5 square metres and 12 inches deep with the sides being level to the ground. There were no barriers around the pond or grill mesh in the pond preventing immersion in the water.</p> <p>The following observations and comments were made by the Coroner:      "While there are a number of building requirements and regulations relating to swimming pools and spas, the legislation completely ignores the presence and potential dangers of ponds, domestic or otherwise...ponds are not referred to in the main body of any piece of legislation and...there is no clear distinction between swimming pools, spas and ponds within State legislation. A pond is a feature built solely for aesthetic purposes, which ideally should be seen without physical barriers...This is a matter that needs to be addressed at a local as well as national level. Pool drowning, along with house fires, account for half of home deaths of children in Australia, the majority of which are under 5 years of age.</p> <p>In any event, a pond is a body of water that access should be restricted to similarly to that of swimming pools and around which all children should be strictly supervised... This death is one that should have been prevented had (the deceased) been under the direct supervision of one of the several adults present on the day."</p>

<p>TAS.2003.229</p>	<p>The deceased and two companions set out at night in a small dinghy with the intention of laying a graball net. Whilst laying the net the dinghy capsized approximately 600m from shore. One of the occupants swam to shore to raise the alarm and the deceased and one other male stayed with the dinghy. The deceased was located the next day by Marine and Rescue divers.</p> <p>Toxicology testing revealed the presence of alcohol and cannabis.</p> <p>During the Coroner's investigation into the death, it was noted that volunteer groups and police working together and supporting each other in their relevant fields was essential.</p> <p>The Coroner encouraged and applauded the involvement of volunteer organisations such as the Royal Volunteer Coastal Patrol, State Emergency Services, Surf Life Saving and St. John Ambulance amongst others. With neither of the three occupants of the dinghy wearing personal flotation devices (PFD's), and all having consumed excess quantities of alcohol throughout the day and evening prior to the fishing trip, it was recommended that in the lead up to the boating season, advertising campaigns relating directly to PFD's and the consumption of alcohol whilst boating be re-commenced. In addition, the Coroner also urged the community to be diligent about these matters at all times throughout the year.</p>
<p>VIC.2000.3740</p>	<p>The deceased (aged 2 years), along with her mother and sibling (aged 3 years), attended a local swim centre complex, where the children used a shallow pool, known as a baby pool, for approx 45 minutes. At that time the mother decided to go to the toilets, located approximately 10 metres away. She instructed the children to remain at the side of the baby pool, with her eldest daughter to watch the deceased. While the mother went to the toilet, the children were left alone for approximately 5 minutes. During this time the deceased has entered the large teaching pool at a point where the water is 50cm deep and drowned. Pool staff were alerted and the deceased was taken from the water, with resuscitation commenced. Following ambulance attendance, the deceased was transferred to hospital, spending several days in intensive care before she passed away.</p> <p>Death was found to have resulted from irreversible cerebral anoxia and terminal inhalation bronchopneumonia resulting from a near drowning.</p> <p>During the inquest a number of issues were considered including parental supervision of the children, the efficacy of the resuscitation attempts mounted by the lifeguards, and the adequacy, or otherwise, of the level of lifeguard supervision at the time of the near drowning.</p> <p>Recommendations were made by the Coroner in relation to a public awareness/educational campaign be delivered at the commencement of the summer period stressing the need for parental/carer supervision at public pools stating that the "first line defence" rests squarely with parents/carers. In addition, the Coroner also called for appropriate signage to be mandatory at strategic locations within the aquatic facility.</p> <p>A copy of the finding is also accessible on the Victorian State Coroners Office website:  <a href="http://www.coronerscourt.vic.gov.au/CA256902000FE154/Lookup/Coronial_Findings_of_Importance/\$file/Nguyen_Cindy.pdf">http://www.coronerscourt.vic.gov.au/CA256902000FE154/Lookup/Coronial_Findings_of_Importance/\$file/Nguyen_Cindy.pdf</a></p>
<p>VIC.2001.340  VIC.2001.341  VIC.2001.342  VIC.2001.343  VIC.2001.344</p>	<p>A triple-vehicle collision occurred when the driver of a prime mover lost control of his vehicle on a poorly surfaced, wet, slippery rutted road. The prime mover then veered onto the incorrect side of the highway, driving over the top of one passenger car before colliding with another. A family of four were fatally injured in the first vehicle, with a passenger killed in the second.</p> <p>During the inquest into the crash the dangerous condition of the stretch of highway was considered, with consideration also given to how the emergence of sudden rain squalls or "microbursts" may have affected the driver of the prime mover. A number of recommendations were subsequently made by the Coroner, including the need for improvement in the method of managing safety and the road infrastructure; reviewing risk analysis and the weighting process for prioritising maintenance; improvements in VicRoads internal investigation, data collection and information exchange systems; a rapid response team to manage and solve hazard and risk problems relating to the road infrastructure and its maintenance system; computer recording systems on trucks; the use of engine brakes by truck drivers; and whether there should be a minimum standard for measuring surface friction values.</p>

<p>VIC.2001.2261</p>	<p>The deceased and 4 others involved in surf life saving went by pelican zodiac boat on a coastal familiarisation tour. About 10 minutes into the journey near a section of the coastline known as the haystack, the pelican faced towards the cliff for sightseeing purposes. After this the boat turned around to continue its journey east.</p> <p>While facing seaward (south) the sea surface lowered exposing rock. With the rocks exposed the twin engine props struck the rock causing it to stall. While trying to re-start the engine, still facing into the sea, a wave struck the vessel causing it to flip-over. All 5 on board ended up in the sea, with the deceased the only one unable to make it to shore. The body of the deceased was later found lying face up on rocks, half in the water.</p> <p>Deceased was wearing a wetsuit but was not wearing a life vest.</p> <p>Following the inquest into the death, recommendations were made by the Coroner concerning the requirement to wear life jackets at all times when aboard a boat or related craft operated by a surf life saving club or agency, review of risk management procedures and training by Surf Life Saving Victoria, and that appropriate protocols be established between Victoria Police and the Marine Board to promote a more cooperative approach in relation to the investigation of any boating incident involving a fatality.</p> <p>The recommendations were referred to the appropriate agencies for consideration.</p>
<p>VIC.2001.3611</p>	<p>The deceased was working on his friends' farm and was using a Ford 6640 power star SL tractor to move some dirt. Whilst attempting to reverse the tractor the three point linkage at the rear of the tractor has caught in the tread of the rear tractor stopping the tractor from going backwards and putting a massive amount of pressure on the three point linkage arm. It is believed that the deceased has exited the tractor and tried to free the linkage arm. While doing so, the bolts attaching the support arm to the linkage arm have snapped from the excessive force causing the support arm to fly straight up hitting the deceased, causing massive facial injuries. The deceased managed to drag himself back into the cab of the tractor where he has been thrown around the cabin due to the tractor jerking backwards and forwards because it was still in gear.</p> <p>A neighbor has seen the tractor jumping backwards and forwards in the one spot and went over and found the deceased slumped over the seat.</p> <p>The cause of death was found to have resulted from massive injuries involving extensive damage to the brain, frontal face, abrasion burns of the arms and legs, stoved in right chest with fractured ribs upper anterior and posterior of the right chest, laceration of the liver, possible fracture without dislocation C1 and C2, and laceration in the region of the anterior aspects of C4 and C5.</p> <p>Recommendations were made by the Coroner in regards to the Victorian WorkCover Authority and Victoria Police establishing a closer relationship in order to ensure that investigations are not truncated, and that training programs of the Authority should emphasise the fact that investigative methodologies not be based upon conclusions / assumptions (as these impact upon the manner in which the investigation is conducted).</p>
<p>VIC.2002.2669</p>	<p>The deceased was a self employed truck driver/owner operator of a transport company, and on the day of his death was employed to move items from one location to another on his truck. Transporting his second load of the day (which consisted of a quantity of heavy gauge sheets of steel), his employer used a JCB front end loader fitted with forklift tines to lift the sheets from the vehicle. The deceased was directing the employer from the ground as to the movement of the forks to enable the plates of steel to be lifted. It appears that the deceased climbed onto the flat back of the truck and has then directed the employer in the lifting of the steel (two sheets: one on top of another). The deceased jumped up onto the steel plate momentarily and told the employer to reverse.</p> <p>The employer looked behind and started to reverse before hearing a noise at the front of the digger. He looked forward and saw the deceased's hands grab for the front bucket of the digger and then disappeared from sight. The deceased was then seen to fall onto the ground under the area of the bucket, with the steel plate landing on him. The employer reversed the digger and put the bucket under the edge of the plate, lifting it off the deceased. He then reversed the digger and pulled the deceased from under the steel.</p> <p>Recommendations were made by the Coroner in regards to revising the licensing and training procedures for all machines that can be adapted for use as a forklift and the imposition of tighter controls when supplying equipment such as tine attachments or machinery with tines already attached.</p>

VIC.2002.2995*	<p>The deceased (aged 7 years) and his 3 siblings were passengers in their fathers' vehicle (which was fitted with a dual fuel system, petrol/liquefied petroleum gas). The vehicle had just been refueled with gas. After departing the service station, there was a smell of gas inside the cabin of the vehicle. Upon a cigarette being ignited by the deceased's father, an explosion occurred inside the vehicle. Recommendations were made by the Coroner (for adoption in the Australian Standard) in regards to the issuing of roadworthy certificates for LPG converted vehicles, Vic Roads Information Notice, and removal of cylinders for testing.</p>
VIC.2002.4065	<p>The deceased (aged 16 years) had been picked up twice by police during the day while affected by 'chroming'. On each occasion he was conveyed home. Following the second return, the deceased left the family residence and ventured to a highway where he stood in the east bound lane. A vehicle traveling along the highway was unable to stop in time and collided with the deceased.</p> <p>During the inquest, a number of features in the history of the case were identified which the Coroner found to provide grounds for specific recommendations. These relate to:</p> <ol style="list-style-type: none"> <li>1. Support for the YSAS 'Safe Place' Proposal,</li> <li>2. Sharing of information in a child's best interest,</li> <li>3. Support for a detoxification/drug rehabilitation facility in Gippsland,</li> <li>4. Effectiveness review of relevant programs at Morwell Aboriginal Co-operative Regeneration of the Woolartbe Werna project,</li> <li>5. 'Advocate for Re-entry to school' position to be created by the Department of Education,</li> <li>6. 'Learn to Up-Link Up' joint program for the Aboriginal Co-op and the Department of Human Services be established,</li> <li>7. Employ more indigenous Juvenile Justice,</li> <li>8. Koori Court Division of the Children's Court.</li> </ol>
VIC.2003.141	<p>The deceased was a passenger onboard a 5.5 metre Caribbean Concorde enjoying an afternoon of fishing in Port Philip Bay with 3 others. At approximately 7.00pm weather conditions changed dramatically from calm to windy gusts with increasing waves. The boat was swamped with three waves which resulted in the sinking of the vessel. All passengers were in the water and the deceased decided to swim ashore to raise the alarm in an attempt to assist the others with recovery.</p> <p>The deceased was located by search and rescue shortly before 3am. He was located in his life jacket with the straps badly twisted about his body. All other passengers survived.</p> <p>In investigating the fatality, the Coroner referred to previous research undertaken by Ms Lyndal Bugeja (the Injury Prevention Research at the State Coroners Office at the time), with improvements to PFD standards in the following areas referred to:</p> <ul style="list-style-type: none"> <li>· the level of buoyancy;</li> <li>· the fastening device;</li> <li>· functionality and comfort; and</li> <li>· ensuring the device remains on the wearer during water entry.</li> </ul>
WA.2001.963	<p>The deceased (a healthy fit young man with no known medical problems) was admitted to hospital and diagnosed as having an infected tooth abscess. X-rays showed an infected wisdom tooth associated with cellulitis of the sub mandibular and submental spaces. The process of draining pus from the abscess passed uneventfully, with the deceased recovering well. Returning to recovery 2 hours post operation, the deceased had an upper respiratory tract obstruction. Multiple attempts were made to reintubate, with the deceased then sustaining a cardiac arrest.</p> <p>Surgical airway was performed and ventilation re-established. The deceased then sustained severe cerebral hypoxia. Despite the return of the deceased to adequate ventilation his significant hypoxia could not be reversed. Death occurred three days later as the result of the oxygen deprivation experienced during the airway obstruction.</p> <p>The cause of death was found to be the result of Hypoxic Brain Injury due to Respiratory Obstruction following Surgery for a Dental Abscess with Cellulitis.</p> <p>Following the investigation into the death, the Coroner found the death to have resulted from a lack of adequate immediate systems response to a recognised risk of airway compromise as follows:</p> <ol style="list-style-type: none"> <li>1. the failure of the system to provide the immediacy of appropriate equipment for a potentially high risk patient in the deceased's circumstances; and</li> <li>2. the lack of appropriate professional support to the senior anaesthetic registrar for an emergency of this type, a known risk of airway compromise.</li> </ol> <p>In addition, the importance of the following were considered: equipment and professional support (especially in the practice of cricothyroidotomy).</p> <p>Recommendations were made in regards to monitoring O2 saturation levels at all times, positioning of functional and user-friendly CO2 monitor, and placing a hospitalized patient in a unit with immediate access to surgical intervention if it becomes necessary until such time as it is clinically likely the infection is under control.</p>

<p>WA.2002.97*</p>	<p>The deceased was riding a motorcycle along a residential road when he lost control on the approach to a roundabout, colliding with the small limestone wall built on the structure. Toxicological analysis revealed that the deceased had a blood alcohol level of approximately 0.135%.</p> <p>At inquest, a number of comments were made in regards to safety issues relating to roundabouts constructed by local Government authorities in Western Australia, along with concerns expressed by the Motorcycle Riders Associations of Western Australia.</p> <p>Recommendations were made in relation to the installation of roundabouts, lighting, identification of hazards and road environment issues.</p>
<p>WA.2003.734  WA.2003.746  WA.2003.750</p> <p>relates also to:</p> <p>WA.2001.1633  WA.2001.1634  WA.2001.1635  WA.2001.1636  WA.2001.1637</p>	<p>An explosion took place in the forward port side ballast tank onboard a Hong Kong registered bulk carrier which was anchored approximately 15 nautical miles north of the Dampier Township. Five crew members died as a result of the explosion, with another three presumed deceased after being blown overboard. Despite extensive searches being conducted for the missing persons, their bodies were unable to be discovered.</p> <p>During the inquest the deaths of the 3 missing crewmen were established beyond all reasonable doubt. A number of comments in regards to safety issues were also raised, specifically in relation to dangerous vapors within the ballast tanks, the Dampier Port Authority, and the Datum Buoys. Recommendations were also made by the State Coroner in regards to the location, provision and storage of datum buoys in Dampier.</p>

## Recent Research of Interest

---

- Driver distractions:  
Requested by State Coroner Graeme Johnstone, Victoria.
  
  - Rock fishing deaths:  
Requested by Coroner Heather Spooner, Victoria.  
Also requested by the NSW Department of Sport and Recreation.
  
  - Incidents involving wall collapses with basketball rings attached:  
Requested by Insurance Australia Group.
    - Police use of capsicum spray:  
Requested by Deputy State Coroner Christine Clements, Queensland.
  
  - Child drowning deaths due to faulty automatic closure pool gates:  
Requested by Coroner David Crerar, New Zealand.
-

## Search Tips

### HOW DO I RESTRICT A SEARCH TO ONLY CASES WHERE RECOMMENDATIONS WERE MADE?

#### Using the Coroners Search Screen

1. Select "Findings" as the document to search.
2. Select the "Recommendations Only" check box.
3. Enter your keywords in the search criteria box.
4. Select which jurisdiction(s) you would like to search.
5. Select any other optional criteria to further narrow the search (i.e. age, gender, year)

The screenshot shows the 'Coroners' Screen' interface. At the top, there is a navigation bar with 'Home | NCIS Search | Case | Documents | Admin | LOGOUT'. The main content area is divided into several sections:

- Select document to search:** Radio buttons for 'Findings', 'Autopsy Reports', 'Police Reports', and 'Toxicology Reports'. The 'Recommendations Only' checkbox is checked and circled in red.
- Search Keywords:** A text box containing 'capsicum spray'. Below it are search tips: 'Le AND = car & tree', 'OR = car | tree', 'NOT = car & ! tree', and a 'Search Tips' link.
- Select jurisdiction to search:** A section with 'All States' checked. Below it are checkboxes for 'Case State' for NSW, VIC, QLD, SA, WA, TAS, NT, and ACT, all of which are checked.
- Optional Search Criteria:** Fields for 'Case Year (Start)', 'Case Year (End)', 'Case Status', 'Case Type (Completion)', 'Sex', 'Age (Start)', 'Age (End)', and 'Age Unit'.

At the bottom, there is a 'User: jessicap' label and three buttons: 'Back', 'Clear', and 'Search'.

#### Using the Query Design Screen

1. From the case details screen, select "Recommendations/Comments Made" from Recommendations field.
2. Enter any other criteria for the basis of your search on the next 5 pages.
3. On the final query design screen, select the fields or 'documents' that you would like to be displayed for returned cases.
4. Hit search.

The screenshot shows the 'Query - Case Detail' screen. At the top, it says 'Specify Search Criteria Page 1 of 5'. The interface is filled with various search criteria fields:

- Age:** Fields for 'Age' (with '>=' and '<=' dropdowns), 'End', and 'Year(s)'. There are also fields for 'Date Notified' and 'End Date'.
- Sex:** A dropdown menu.
- Years In Aus:** A text box.
- Marital Status:** A dropdown menu.
- Product Related:** A dropdown menu.
- Case Status:** A dropdown menu.
- Notification:** A checkbox.
- Completion:** A checked checkbox.
- Suburb:** A text box.
- Post Code:** A text box.
- State:** A dropdown menu.
- Country:** A dropdown menu.
- Case State:** A list of states: NSW, VIC, QLD, SA, WA, TAS, NT, ACT. 'VIC' is selected.
- Case Type:** A dropdown menu.
- Intent Type:** A dropdown menu with 'Adverse Effects or Complication of M' selected.
- Indigenous:** A dropdown menu.
- Inquest Held:** A dropdown menu.
- Recommendations:** A dropdown menu with 'Recommendations Made / Warnings Made' selected and circled in red.

Below these fields is the 'Document Search' section with fields for 'Text in Documents', 'Document Type' (set to 'Autopsy'), 'Search Type' (set to 'Keyword Search'), 'Score' (set to '20'), and 'Distance' (set to '5').

At the bottom, there is a 'User: jessicap' label and four buttons: 'Back', 'Clear Screen', 'Go to Page 2', and 'Finish'.

# Fatal Facts Feedback Form

## SPECIAL EDITIONS

Please indicate any areas of interest you would like to see featured in future special editions i.e.: Drowning in swimming pools.

---

---

---

---

## ADDITIONAL COMMENTS / SUGGESTIONS ABOUT FATAL FACTS

---

---

---

---

Name

Address

Phone

Please return to:

National Coroners Information System  
C/- Victorian Institute of Forensic Medicine  
57-83 Kavanagh Street  
SOUTHBANK VIC 3006  
Fax: 03 9682 7353